On-Time Preventable Hospital and ED Visits

Self-Assessment Scripted Exercise

Team consists of:

- Facilitator [Tom]
- Program Champion (Quality Assessment and Assurance [QAA] Coordinator) [Beth]
- Director of Nursing (DON) [Mary]
- Nurse Manager Unit A
- Nurse Manager Unit B
- Minimum Data Set (MDS) Coordinator
- Staff Development Coordinator (SDC)
- Evening Supervisor
- Administrator
- Social Worker

Program Champion: Hi, everyone, we're here today to review our practices to prevent hospitalizations and ED visits, and to learn how we can use On-Time to improve our preventive practices. I know everyone is busy so let's dive into the Self-Assessment right away so we don't waste time. The On-Time Self-Assessment is divided into four sections: Assessment, Prevention Practices, Communication, and Investigations/Root Cause Analysis. Let's start with Assessment. We'll begin by talking about how we currently use tools to monitor transfers to the hospital and ED.

Nurse Manager A: Isn't every one of our frail, elderly residents at risk for decline and possible hospitalization?

Program Champion: Yes, that's true, but each resident has his or her own unique risk factors. We are trying to screen for each resident's conditions and symptoms that could lead to a hospitalization or ED visit and work together to communicate about the risk. Then, we can update the care plan with interventions aimed at preventing some of these hospitalizations.

Nurse Manager B: Some hospitalizations can't be avoided.

Facilitator: Of course, but research has shown that a significant proportion of hospital and ED visits can be prevented with careful monitoring and timely interventions. Also, some hospitals or physicians may not be aware of your facility's capabilities.

Staff Development Coordinator: That's right. For instance, all of our nurses have been trained on IV insertion and our pharmacy provides backup with an IV nurse if we have trouble. We can manage residents here at the facility who need IV hydration or medications.

Administrator: We need to make sure that all of our physicians and nurse practitioners know that. When we can manage our residents here at the facility and avoid hospitalizations, the residents remain in their familiar setting with our staff who know them well, and residents aren't exposed to nosocomial infections.

Program Champion: Good point. I think that as we progress through the Self-Assessment today you will see how the On-Time reports will help us to identify at–risk residents earlier than we currently can. Our ability to intervene earlier to prevent resident decline and the need for resident transfer is going to be greatly enhanced. Are there any other questions before we begin? [Pause for questions.] Okay; then let's get started. We have a lot to talk about. Thank you all for taking the time to meet with me today. The first section of the Self-Assessment is about screening for hospital transfer risk. Do we have a written policy and procedure on assessing residents at risk for a hospital transfer or ED visit?

DON: We don't have a written policy. I know this is an important aspect of care for our residents but we have never developed a policy and procedure to cover this? Is this something that other facilities have in place?

Facilitator: This is a new area of interest and many facilities do not have a policy in place. Even though you don't have a policy to screen for hospitalization and ED visit risk, I imagine you have policies and procedures in place to address how clinical changes that could lead to a hospitalization are evaluated, communicated, and documented. Is that true?

Nurse Manager B: Yes, we have protocols for how we communicate clinical changes. For example, we have a policy that says we notify primary care providers with lab results. All lab results are reviewed by the resident's physician; they have to be faxed within 4 hours. Sometimes results require us to call when we receive them. Our policy and procedure also includes very specific protocols for how we handle lab results related to anticoagulation therapy. These are always called to the resident's physician upon receipt. We need to make sure we get orders for the residents' continued anticoagulant therapy and their next lab to monitor the impact of it. We recognize that anticoagulants are very high-risk medications.

Facilitator: Yes, that's the kind of policy and procedure that I'm thinking of. It's interesting that you mention anticoagulants, in particular. You probably remember that when we discussed the On-Time Transfer Risk Reports, I mentioned that it takes into account several classes of high-risk medications, including anticoagulants, when determining the residents at highest risk for transfer. Let's talk about other protocols you may have. Do you have other policies or procedures around communicating clinical changes?

Nurse Manager A: We recently started using the SBAR technique for communicating with our physicians. We just completed our training. We try to think ahead of what we want to say and make sure we include all the information the physician or nurse practitioner needs to make a decision. It takes a little extra time to get ready to make the call, but I think they like it. It's more efficient because we don't have to stop midway through the call to go get a piece of information from the medical record.

Facilitator: That sounds like a good skill to work on. What is the process that you use to gather the information before making the call?

Nurse Manager A: I had to call Dr. Brown last evening about one of our residents. The resident was more confused than usual, lethargic, and not eating or drinking. The doctor wanted to know when he had last been admitted to the hospital and if he had any advance directives in his record. I had all my information on his intake and output and recent symptoms but had to go look for the advance directives and find the dates for his last hospitalization. Thinking back to what we discussed yesterday, that information would have been on the Transfer Risk Report, wouldn't it?

Facilitator: Yes, you're right, that information would be available on the Transfer Risk Report if the resident was at high or medium risk for transfer. Let's hold that thought and talk a little more about communicating changes in resident status. Do you have a policy about communicating with hospitals or emergency departments?

Evening Nursing Supervisor: Yes, we always call ahead with a report regarding why we're sending a resident.

Facilitator: Who is responsible for making that call? Is there a protocol of what types of information you include?

Evening Nursing Supervisor: The call is usually made by the charge nurse or nursing supervisor on the evening and night shifts. On days, it's the nurse manager or nursing supervisor. We include a description of the problem, current diagnoses, any recent lab or x ray results, and the resident's DNR or DNH status.

Facilitator: What is the goal of this practice? Is it effective?

Evening Nursing Supervisor: The goal is to make sure the ED knows a nursing home resident is on the way so that they can be seen as soon as possible. We also try to give them some report of what interventions we may have tried and recap discussions that we may have had with the family. I think it's pretty effective and the nurses in the ED appreciate the heads up.

Facilitator: Are there any other processes that you use to communicate changes in resident status? What about notifications to families?

Nurse: We always notify families whenever we have to notify the physician or NP about a change in a resident.

Facilitator: Who is responsible for doing that?

Nurse: The same nurse who notifies the physician is the nurse that calls the family.

Facilitator: How about the paperwork side of communication? Do you use standard forms for transfer to hospital?

Nurse: Yes, we use a three-page referral. And, we recently started using the INTERACT checklist of information to be sent with the resident to the hospital.

Facilitator: Where do you find the information that you need to send with the resident? Is it in the EMR?

DON: Some is in the EMR, some we have to make copies of before sending the resident out – like the DNR forms.

Facilitator: Is there a way this process could be improved?

DON: Well, one way the process could be improved would be to have a consolidated method for documenting the transfer information. I know that our EMR is going to have some changes so that we'll have an actual transfer note. Can you tell us about that in case someone in the group isn't familiar with the changes that are planned?

Program Champion: Sure. There is a standardized set of data elements that are needed in order to populate the On-Time reports. We have worked with our software vendor to develop a transfer note that we think will best meet our needs. Several nurses had input on the design of it. It will allow a standardized, high-level summary of the reasons for transfer to be documented in the EMR and allow efficient documentation regarding what treatments, if any, were provided prior to transfer.

Nurse Manager A: Jessica, my evening nurse, was in the workgroup for developing the format of the transfer note. She said it is going to be awesome.

Facilitator: I'm glad you're looking forward to the transfer note being activated in the EMR. So, it sounds like you have several protocols for communicating clinical changes – you call abnormal lab reports to the physicians, you notify the ED that you're sending a resident, you are using SBAR and Interact. We just heard about one way the transfer process could be improved. Do you think any of the other processes could be improved?

DON: I think we're doing pretty well at communicating changes, but it would be nice to be able to intervene earlier for our residents so that we could avoid that call to the hospital or ED – isn't that what we're focusing on here?

Program Champion: You're right, Mary. Let's think about screening for potential hospital transfers by identifying residents at risk for hospital transfer. What types of residents would you expect to be at risk for a hospital transfer?

Evening Nursing Supervisor: I think that residents who have just returned from a hospital stay or have been in the ED are at high risk.

Nurse Manager A: Residents who have certain diagnoses, like CHF, diabetes, and COPD.

Nurse Manager B: Residents who take certain medications. We already talked about anticoagulants but I think that residents with insulin, certain heart medications, and more are also at high risk.

Facilitator: Exactly. How would you go about identifying those residents who have been in the hospital or ED, have high-risk diagnoses, or take high-risk medications?

DON: We could check the MAR for the medications. Or maybe the pharmacy could send a list.

Facilitator: Is anyone responsible for doing that now?

DON: No, and it would need to be updated at least every month. Actually, a lot can change in a month. There is no way we could currently get that information more frequently than that, though.

Facilitator: So there is no way to currently collect that information from your EMR?

DON: No, we would currently have to pull the information from multiple sources. It would take forever.

Nurse Manager A: By itself, that medication or diagnosis information is somewhat important. But, for instance, some residents have been on insulin or anticoagulants for years without any problems; others require frequent adjustments and have other confounding issues. I'd be more interested in the ones whose meds need adjustments and have other problems.

Program Champion: So, it sounds like what you're saying is that if you had the medication information in combination with other risk factors, that you could identify the residents most at risk?

Nurse Manager A: Yes, I think that's right.

Program Champion: That's what the Transfer Risk Report would give us—residents with recent hospitalizations and ED visits, high-risk diagnoses, and recent clinical changes.

Nurse Manager A: That would be very useful.

Program Manager: Let's move on to the second part of the Self-Assessment, the prevention plan. Do we develop a care plan for residents at risk for hospital transfer?

MDS Coordinator: Well, we don't call it a care plan for preventing a hospital transfer, but we develop care plans for residents who have returned from the hospital after being treated for COPD or pneumonia or whatever, to try to avoid that problem from recurring.

Facilitator: How do you develop those care plans?

Nurse Manager A: We have a book of sample care plans that we use on our unit.

Facilitator: Do you ever use care paths?

Nurse Manager A: I don't think so.

Facilitator: Care paths provide information on how to evaluate symptoms of various conditions that frequently lead to a hospitalization. Care paths help you decide when a symptom or cluster of symptoms has reached the point where it needs further evaluation by the physician either at the nursing home or at the hospital.

Nurse Manager B: I could see that being useful. Is it something that you use with every resident? That sounds like a lot of work.

Facilitator: Care paths are useful for evaluating all residents with chronic conditions like CHF or when there has been a change, like mental status or behavior change. You could use the Transfer Risk Report to identify those residents at highest risk and start with them.

Facilitator: Do you have routine discussions with the resident and family about advance care planning?

Social Worker: I go over advance directives on admission with the resident and their family. And, when a crisis occurs, like an acute illness, I may review the plan with the family, but we don't do it on a routine basis. That's probably something we should work on.

Evening Nursing Supervisor: Yes, a lot can change with a resident over time and when you're trying to get someone out the door to the ED, that's not when you want to rethink the advance directive. I think many residents would choose not to go to the hospital if they could make that decision.

Facilitator: Okay, that sounds like an area you'd like to work on. Does your electronic medical record provide you with a list of residents and their code status?

DON: Yes, I think it does, but you really need to see other factors, like how many times they've been in the hospital or ED over the last few months, for what reasons, and what other problems they have to select which residents should be re-evaluated in terms of advance care planning.

Program Champion: Yes, exactly what the Transfer Risk Report and ED Treat and Release Report will give us.

Facilitator: Let's move on to the communication practices part of the self-assessment. Tell me about the meetings that you have where hospital transfer prevention is discussed.

DON: Everyday at morning meeting with department heads, we review transfers to the hospital and ED and any admissions, including new admissions as well as readmissions. We also go over that same information at shift report with the nurses and nursing assistants. But that's not prevention.

Facilitator: Who is at the morning meeting?

DON: The administrator, the department heads—Activities, Dietary, Social Services, Maintenance, the admissions coordinator, and myself.

Program Champion And at the shift report—I assume just nursing staff—licensed and nursing assistants?

DON: Yes, unless the dietitian sits in to talk about any particular issues around fluid intake, food preferences, or weight loss.

MDS Coordinator: We talk about recent transfers at the care plan meeting and when the medical director comes to make rounds. But, same as Mary said, that's not about prevention.

Facilitator: Tell me about Medical Director rounds. How is this done?

DON: The Medical Director comes once a week to make rounds on his patients. He goes to each unit and makes rounds to see patients with the nurse manager. They also discuss any other residents who are not his, but that the nurse has a concern about. I come along to listen on each unit.

Facilitator: Do you discuss residents at risk for transfer?

DON: No, but we do talk about any resident recently returned from a hospital stay or ED visit.

Facilitator: Sounds like there might be an opportunity to include a prevention discussion, especially when you have the On-Time reports available to you with a list of residents most at risk.

DON: I agree.

Program Champion: We also discuss hospitalizations and transfers at the quality improvement meeting. We put together a monthly summary of all transfers that have occurred, showing the type of transfer (hospitalization or ED visit), time of day, day of the week, and the reason it occurred. We do this for each unit and then roll it up to a facility-level report. **Facilitator:** Who is responsible for doing this?

Nurse Manager A: We do it, the nurse managers on each unit. It's a pain. We create a spreadsheet on the computer but have to search through each individual medical record to find the details. It involves going to the census records to see all the hospital admissions and the 24-hour report for ED visits. Then we go into each transferred resident's record and read through the nurses' notes for that date to figure out what happened.

Facilitator: How frequently is it done?

Nurse Manager B: We do it on a quarterly basis.

Facilitator: And what is done with that information?

Program Champion: We report it at the QI meeting to the administrator and the Medical Director.

Facilitator: Then, what do you do with the information?

Program Champion: We look for any trends, like if a particular unit is sending more residents than anyone else, but it seems to vary every quarter. One quarter unit A sends more residents, the next quarter unit B sends more. It doesn't seem to tell us that much information.

Facilitator: If you see a trend, what do you do?

Program Champion: We would try to figure out what was going on in that unit. Maybe they had new staff or the residents had the flu or something like that.

Facilitator: Okay. That sounds like you're doing a root cause analysis. That's covered in the last section of the Self-Assessment. Before we go there, let's finish up the communication section. Are there any other meetings where transfers or transfer prevention is discussed?

DON: No, I think that about covers it.

Facilitator: Okay, tell me about trainings that you've offered to staff on high-risk clinical conditions like CHF or COPD.

Staff Development Coordinator: Last month, our pharmacist gave an in-service on medications to treat COPD. And, about 6 months ago, our Medical Director gave a talk to the nurses on CHF after we had several residents hospitalized for exacerbations of their CHF that he thought should have been caught earlier—before the residents required hospital treatment.

Facilitator: Any followup after the CHF training? Have you been tracking transfers related to CHF?

Nurse: No, but that's a really good idea. Wouldn't one of the On-Time reports cover that?

Facilitator: Yes, the Monthly Summary would show that, by unit and for the facility as a whole. You could also track it on the Key Metrics Report to see transfers over 12 months. You could ask your EMR vendor to set it up as an additional item of special interest.

Staff Development Coordinator: That would really help and I think the nurses would like to see how they're doing. We could post the results in the break room every month.

Facilitator: Great idea. Let's finish up this section. Were there any trainings on effective communication? You mentioned that you were recently trained on using SBAR.

DON: Yes, the SBAR training was offered to all the nurses.

Facilitator: Have you offered any communication training to the nursing assistants?

Staff Development Coordinator: Yes, we have been rolling out various components of TeamSTEPPS. So far we've introduced Stop and Watch with them and plan to add the Two Challenge Rule.

Facilitator: Similar to tracking results specific to CHF, you could track numbers of transfers and hospitalizations after these key trainings take place to see if the new communication interventions have affected resident outcomes. To see where—on what units—there has been an impact and where maybe retraining might be needed. I can see that these On-Time reports will be very helpful to you. Let's move on the last section of the Self-Assessment on root cause analysis. You mentioned earlier that you use your quarterly log sheets to identify any trends in transfers and then take that information to the QI committee. Do you investigate each transfer to see if it could have been prevented?

DON: We don't call it root cause analysis. But, as I explained, we look for and record all the details around the transfer.

Facilitator: Do you use any tools for this?

Nurse Manager A: No, we just look for information to fill in the cells in the spreadsheet. I guess we're filling in details but not looking so much as why the transfer happened. I mean we know that the transfer happened because, for example, the resident was short of breath. We don't investigate what led to the resident getting short of breath. I suppose if we were really on top of things, we'd notice that this resident had had a cold the week before and had not fully recovered or if the resident had CHF that their weights had been going up.

Facilitator: Who participates in reviewing the details of the transfer?

Program Champion: The administrator, the DON, the Medical Director, the Staff Development Coordinator, the Nurse Manager who put the information together, and myself.

Facilitator: In the course of the investigation, it sounds like you review the medical record. Do you talk to the nurse who was taking care of the resident when the transfer became necessary? Do you talk to the clinician who authorized the transfer?

Nurse Manager A: No, we just review the medical record.

Facilitator: Does anyone involved speak to the nurse involved or the physician who ordered the transfer?

DON: No, not routinely. Once we had a case where the family complained to the State that their family member should have transferred sooner, so we conducted a thorough investigation and spoke to everybody involved. But that was a special case.

Facilitator: In the end, was that investigation successful in determining what had happened?

DON: Yes, we found out that lab reports that came in after 5 p.m. were coming to the business office fax and not to the nursing units. That's when we got fax machines for each unit and instituted the policy to require that all labs be faxed to the provider within 4 hours and that nurses follow up on abnormal results.

Facilitator: I see, so it sounds like that time, an in-depth investigation led to significant changes. Does the team decide if the transfer could have been prevented?

DON: No, we don't do that and I'm not sure that we have clearly defined what a "preventable" transfer is and therefore aren't examining such cases as well as we probably could. It is difficult to assemble the treatment history and understand other health issues that we need to know to make adjustments to the resident's care plan.

Facilitator: Based on the input of the nurse managers and Beth [QAA Coordinator], it seems that there is the potential to make some significant enhancements related to investigations and root cause analysis of hospital transfers. What I am hearing is that there is tracking of hospital transfers as part of QAA but that preventable transfers are not clearly defined and therefore, at this point, not investigated in a structured way. Do the rest of you agree with the Nurse Managers and Beth [QAA Coordinator]?

Team (except for Nurse Managers and QAA Coordinator): Yes.

DON: I think we have the next item on our to-do list. We need to define preventable transfers and how we will investigate them. This approach sure seems more proactive than only tracking details on hospital admissions and ED visits.

Program Champion: As we move through the On-Time reports together, we will see how On-Time is going to enhance our team's ability to identify residents at high risk for transfer, plan timely interventions, and investigate hospital transfers to determine if any were preventable. I think this has been a very productive discussion. Thank you all for your input.

To wrap up the meeting, let's recap what we've heard today**:**

- It's possible that not every physician or hospital knows this facility's capabilities – especially around IV therapy.
- Advance directives are addressed on admission and in a crisis, but not on a routine basis.
- Medical Director rounds do not include a focus on prevention by including a review of residents most at risk for hospital transfer. This is a missed opportunity.
- Currently there is no process for monitoring the effectiveness of staff trainings on a specific area of resident quality of care (e.g., reducing preventable hospital transfers).
- Investigations of hospital transfers are limited to the collection of information or details about the transfer but do not attempt to determine if a system problem had an impact on the transfer.

Program Champion: Does that accurately sum it up?

Team: Yes.

Facilitator: At a few points during our discussion, I mentioned how the On-Time reports can help you in your practices related to preventing avoidable hospital transfers. I think the On-Time reports could be very helpful to you in addressing the opportunities for enhancement that we identified. They can provide timely information on clinical conditions to enhance care planning. I will work with you to identify the reports you want to adopt and how to integrate the use of the reports into existing meetings. If you decide a new meeting will be needed to communicate the information, I'll help you through the processes related to creating that meeting as well. That will be the focus of our next session.

Program Champion: Thanks for a great discussion, team.

On-Time Preventable Hospital and ED Visits
Menu of Implementation Strategies

(for use with the Implementation Scripted Exercise)

Avoidable Hospital Transfer Prevention Menu of Implementation Strategies		
	Existing	**New**
Transfer Risk Report – High Risk and Medium Risk		
Care Plan Meetings	X	
Dietary Department Internal Review	X	
Nurse Shift Change Report	X	
Nursing Leadership Meeting	X	
Pharmacist Medication Review Meeting	X	
Rehab Department Internal Review	X	
Weekly Transfer Risk Meeting		X
Weekly Wound Review Meeting	X	
ED Treat and Release Report		
Care Plan Meetings	X	
Dietary Department Internal Review	X	
Nurse Shift Change Report	X	
Nursing Leadership Meeting	X	
Pharmacist Medication Review Meeting	X	
Rehab Department Internal Review	X	
Weekly Transfer Risk Meeting		X
Weekly Wound Review Meeting	X	
Monthly Summary of Hospital Transfers by Facility or Unit Report		
Nursing Leadership Meeting	X	
Quality Improvement Review	X	
Root Cause Analysis for Hospital Admissions//ED Visits		X
Monthly Summary of Hospital Transfers by Provider		
Nursing Leadership Meeting	X	
Root Cause Analysis for Hospital Admissions//ED Visits		X
Key Metrics Trend Report		
Nursing Leadership Meeting	X	
Quality Improvement Review	X	
Root Cause Analysis for Hospital Admissions//ED Visits		X

On-Time Preventable Hospital and ED Visits
Meeting Descriptions and Suggested Meetings Where Reports Can Be Used
(for use with Implementation Scripted Exercise)

Nursing Home Meetings	Meeting Description	Typical Attendees and Leads	Transfer Risk Report	ED Treat and Release Report	Monthly Summary by Facility or Nursing Unit	Monthly Summary by Provider	Key Metrics
Care Plan Meetings	Weekly review of resident care plans. Reports help team make decisions about care plan changes.	Multidisciplinary team DON or ADON typically leads the meeting.	X	X			
Dietary Department Internal Review	This is a weekly meeting within the Dietary Department. Report supports nutrition plan review and changes.	Dietary Department staff Director of the Dietary Department typically leads the meeting.	X	X			
MDS Assessment Documentation	Reports may be used to support MDS nurse review of resident records and aids MDS assessment documentation.	MDS Nurse and other disciplines responsible for MDS assessment documentation, including Dietary and Rehab	X	X			
Nurse Shift Change Report	Nurses meet at change of shift to review resident clinical and risk status. On-Time risk reports help identify residents at risk for potentially avoidable hospitalizations and/or ED visits	Nurse managers or charge nurses Nurse managers or charge nurses typically lead the meeting.	X	X			
Nursing Leadership Meeting	Nursing leadership meets to review issues concerning nurse staffing, and relationships with other facility departments, outside entities (hospitals, EDs), physicians, pharmacy, and suppliers that affect resident care.	DON, nursing supervisors, nurse managers or charge nurses, MDS nurse, QI nurse, infection control nurse DON typically leads the meeting.	X	X	X	X	X
Pharmacist Monthly Medication Review	The pharmacist and director of nursing or nurse manager review resident medication regimens to determine if medications may contribute to transfer risk and if medication regimen adjustments should be recommended based on resident status.	Pharmacist and DON or nurse manager Medical Director may also participate.	X	X			

Nursing Home Meetings	Meeting Description	Typical Attendees and Leads	Transfer Risk Report	ED Treat and Release Report	Monthly Summary by Facility or Nursing Unit	Monthly Summary by Provider	Key Metrics
Quality Improvement Review	Quality committee meets monthly or quarterly to review facility quality metrics, review ongoing quality projects, and initiate new or retire completed quality projects.	QI Committee, Department heads, including administrator and Medical Director (or physician/APRN designee)			X	X	X
Rehab Department Internal Review	Department team weekly review of rehab patients or residents in need of rehab. Report data help identify residents with new ADL decline, fall risk, or fall injury, therefore at risk for potentially avoidable hospitalization or ED visit and in potential need of therapy.	Rehab Department staff Rehab director typically leads the meeting.	X	X			
Root Cause Analysis for Avoidable Hospitalization/ ED Visit	Multidisciplinary team review of recent hospitalizations and ED visits. Risk and trended reports provide insights into why these hospitalization/ED visits occurred.	DON or ADON, nurse manager, wound nurse, QI director DON, QI director, or QI staff lead the meeting.	X	X	X	X	X
Weekly Nutrition Risk Huddle	Nurse/dietitian/ nursing assistant weekly huddle to review nutrition status and confirm appropriate interventions are in place for residents at risk of transfer. Reports identify residents with nutrition/dehydration risk and the meeting elicits feedback from nursing assistant staff caring for the residents, and perspective of the nurse and dietitian.	Charge nurse, dietitian, and nursing assistants Other staff may attend, such as wound nurse, Social Services, MDS nurse. Nurse and a dietitian co-lead the meeting.	X	X			
Weekly Risk Huddle for Nurse and Rehab Managers	Weekly huddle to review residents at risk for ADL decline or fall or with fall injury and in potential need of therapy.	Nurse manager and Rehab Director or rehab therapist	X	X			

Nursing Home Meetings	Meeting Description	Typical Attendees and Leads	Transfer Risk Report	ED Treat and Release Report	Monthly Summary by Facility or Nursing Unit	Monthly Summary by Provider	Key Metrics
Weekly Transfer Risk Meetings	Multidisciplinary team review of residents at risk. The purpose of using the reports is to identify persons with risks associated with avoidable hospitalization/ED visits, review care plans, and help update interventions.	DON or ADON, nurse manager, dietitian, and Rehab Director or rehab therapist, depending on focus of meeting. DON or ADON leads the meeting.	X	X			
Weekly Wound Review Meetings	Multidisciplinary team weekly review of residents with stage 2 or above pressure ulcers at risk for infection who potentially require hospitalization/ED visit. Reports provide information about current and changing risks for pressure ulcer healing and can aid root cause analyses and decisions about ulcer treatments and interventions.	DON or ADON, nurse manager, wound nurse, physician, NP, and QI Director. The team conducting wound rounds typically attends this meeting for a more detailed review of the resident chart and current care plan interventions. Physician, dietitian, therapist, and QI staff, who may not attend wound rounds, attend this meeting. DON typically leads the meeting.	X	X			

Abbreviations used: (ADON) Assistant Director of Nursing; (DON) Director of Nursing; (NP) Nurse Practitioner; (MDS) Minimum Data Set; (QI) Quality Improvement; (MD/APRN) Medical Doctor/Advanced Practice Registered Nurse

On-Time Preventable Hospital and ED Visits
Communication Practices Grid
(for use with Implementation Scripted Exercise)

Meeting	Hospital/ED Transfer Prevention Discussed Yes/No	Meeting Chair/Leader Name and Discipline	Staff Invited and in Attendance (indicate A – Always, V- Varies as Needed)	Frequency of Meeting (Weekly, Biweekly, Monthly, Quarterly, Change in Condition, As Needed)
Shift Report With Licensed Staff	Previous hospitalizations/ED visits discussed but not residents at risk for transfer	Nurse manager or charge nurse	Nurse manager or charge nurse with licensed staff on each unit (A)	Every shift
Report or Brief With Nursing Assistants	As above	Nurse manager or charge nurse	Nurse manager or charge nurse and nursing assistants on duty each shift (A) Attend periodically, based on needs of the residents on the unit: the dietitian (V), the social worker (V), the Activities Director (V), rehab staff (V)	Every shift
Report or Brief With Department Heads	As above	Administrator	Department heads (A), including: • Administration • Dietary • Nursing (DON and nurse managers) • QAA Coordinator • Social worker • Activities Director • Rehab Director • Food Services supervisor • Maintenance Director (including Laundry and Housekeeping)	Daily on business days (Monday–Friday)
Medical Staff	As above	Medical Director/Dr. Bishop	All attending physicians (A) and NP/PAs (V)	Quarterly
QAPI or Performance Improvement Plan Meeting	As above, except when related to a complaint	QAA Coordinator	All department heads noted above (A) and the Medical Director (A)	Quarterly

Meeting	Hospital/ED Transfer Prevention Discussed Yes/No	Meeting Chair/Leader Name and Discipline	Staff Invited and in Attendance (indicate A – Always, V- Varies as Needed)	Frequency of Meeting (Weekly, Biweekly, Monthly, Quarterly, Change in Condition, As Needed)
Care Plan Meeting	As above	MDS Nurse	Interdisciplinary team members, including the nurse manager (A), the dietitian (A), the social worker (A), the Activities Director (A), rehab staff for residents receiving therapy (V), the resident (V) and his or her family (V), and the MDS Nurse (A). Note: Residents and/or their families are always invited to care plan meetings but don't always choose to attend.	Weekly
MD/APRN Rounds	As above	Nurse manager or charge nurse	Medical Director (A) and primary care physicians/NPs/PAs(V) and nurse manager or charge nurse (A)	Weekly
Report or Brief With Dietary Department	As above	DON	Dietitian (A), food services supervisor(V), and DON (A)	Weekly
Report or Brief With Social Services Department	N/A	NA	N/A	N/A
Report or Brief With Therapy Department	As above	DON	Rehab Director and DON (A)	Weekly
Report or Brief With Other – Pharmacist Consultant	As above	DON	Pharmacist consultant and DON (A)	Monthly
Report or Brief With Other – Nursing Leadership	As above	DON	Nurse managers (A), evening and night shift nursing supervisors (A), Staff Development Coordinator (A), QAA Coordinator (A), MDS Nurse (V), infection control nurse (V)	Weekly

On-Time Preventable Hospital and ED Visits

Implementation Scripted Exercise – Selecting Preventable Hospital Transfer Reports and Meetings in Which To Use Them

Team consists of:

- Facilitator [Tom]
- Program Champion (Quality Assessment and Assurance [QAA] Coordinator) [Beth]
- Director of Nursing (DON) [Mary]
- Nurse Manager Unit A
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- Staff Development Coordinator (SDC)
- Evening Supervisor
- Administrator
- Social Worker

Scene One: Change Team Meeting

Setting: At this point, the team has completed their review of the Self-Assessment and is ready to move ahead with selecting the On-Time Preventable Hospital Transfer reports and determining how they will implement them. The Menu of Implementation Strategies Worksheet has been completed by the Director of Nursing (DON) and reviewed by the Facilitator and Program Champion. The team is assembled: the Facilitator [Tom], the Program Champion [Beth], the DON [Mary], the Nurse Manager from each unit [Jill] (Nurse Manager Unit A) and Frank (Nurse Manager Unit B)], the Staff Development Coordinator [Susan], the Evening Nursing Supervisor [Henry], the Social Worker [Laura], and the Administrator [Betty].

Program Champion: Good afternoon. We have made great progress thinking about our preventive practices for hospital transfers using the Hospital Transfer Self-Assessment. The task at hand this afternoon is to determine which Preventable Hospital Transfer reports we will integrate in our current care processes, and to determine how we'll begin to pilot these reports.

Facilitator: Facilities generally start implementation on one unit with just one or two reports. Starting small allows refinements to be made to the rollout process before rolling the program out to the remainder of the facility. Look at the Menu of Implementation Strategies to help you think about what meetings you could enhance by adding a discussion of the high-risk residents identified on these reports. Have you given any thought as to which unit you will begin the pilot on?

Nurse Manager Unit A: We thought we'd start on my unit.

Facilitator: Jill [Nurse Manager A], what led the team to determine that Unit A was the right unit to start with?

Nurse Manager Unit A: Well, our unit is one of the long-term care units with a high dementia population. Unfortunately, we've had a lot of transfers to the ED and hospitalizations lately. From what we learned earlier about the On-Time reports, I think we could use the reports to identify which residents are at highest risk. You see, our residents are very fragile and many cannot communicate their symptoms to us. We rely on picking up subtle changes that can indicate that a chronic problem is about to flare up. For example, last week one of our residents was sent to the ED with a fever during the night shift. Our nursing assistant did say that her energy level had been low for a while and she had not been eating well over the past week, but it was not soon enough to prevent the ED visit. Her physician wanted to send her to the ED for evaluation of a possible infection. The report from the ED showed that she had had two previous ED visits in the last month. We probably would have made changes in her care plan earlier if we had been alerted to these problems sooner.

Program Champion: You're right; the Transfer Risk Report will provide you with a list of residents at high or medium risk along with their advance directives and previous ED visits and hospitalizations over the past 90 days. Unfortunately, as you know, when residents have cognitive and communicative limitations, it is not always possible to determine when they are not feeling well and it is hard for nursing assistants to let the nursing staff know about changes in symptoms early enough. She would have come up on the Transfer report earlier and we may have been able to treat her in the nursing home. We have IV therapy and that may have helped if we had spoken to her physician in time. The ED identified pneumonia as the cause of her fever and she is now on antibiotics. The recent experience for the resident that you described, Jill [Nurse Manager A], and our high rate of hospital transfers show that we have a tremendous opportunity to do a better job for our residents.

Facilitator: Well, good, but I'm sorry you and the resident had to have that experience. Before we move on, let's review what we discussed last time. During our last meeting, you completed the Self-Assessment. After going through the Self-Assessment, you wanted to enhance medical director rounds by including a discussion of those residents most at risk for a preventable hospitalization or ED visit and not limit the discussion to only those residents who had just returned from a hospital stay or ED visit.

Team: Yes, that's right.

Nurse Manager Unit A: Dr. Bishop comes weekly to make his rounds.

Facilitator: Have you thought about how you'll integrate the use of the report into your rounds with him?

Nurse Manager Unit A: My plan is to print the Transfer Risk Report the morning he's due and, as we make rounds on his residents, I'll make sure that we stop in on the residents listed on the high-risk report. I don't think that it will add more than about 5 or 10 minutes to his rounds. I'll review the report in advance and select the residents with the most pressing issues. I'll use my knowledge of the residents and their wishes along with the information in the report. Does that sound reasonable?

DON: Yes, but I think you should take a few minutes before you begin rounds to orient him to this new process. I don't foresee any problems, and he'll be especially glad to hear about our plans to enhance our review of advance directives. He's a big proponent of that.

Nurse Manager Unit B: I like Jill's [Nursing Manager A's] approach. I think that will work. After she's had a chance to try this new process, I'd like to start. In other words, I don't want to wait too long before my unit gets involved.

Facilitator: Okay. I like your enthusiasm. Are there other staff besides the Medical Director for whom the information on the Transfer Risk Report would be valuable?

DON: I'd like to see the information on that report shared with the consultant pharmacist. He reviews medication records and provides us with a list of residents who need followup, for instance, when a resident needs labwork or a notification to the physician regarding the possibility of drug-drug interactions. I'd really like to have him see the list of residents with more than 15 medications or on high-risk medications, along with their current clinical conditions and high-risk change in conditions. This information has not been available to him all in one place. This may stimulate a review of the medications that may cause some of the hospital transfers.

Nurse Manager Unit A: I agree. And, I'm thinking I'd like to share the information on the Transfer Risk Report with each of the physicians and nurse practitioners who have residents on our unit. They come at least once a month to make rounds. I'd like to show this report to them so that they can see which of their residents are at highest risk. I want to ask if they have any input regarding any residents on the list; in other words, do they agree that the residents on the list are at high risk for transfer? Secondly, I'd like to know if they'd like to make any changes to ensure that the residents' orders and care plans reflect the most appropriate prevention strategies. For example, some, but not all, of the physicians have standing orders for daily weights for CHF patients and parameters for when to call the physician. I'd like to request that we get those types of orders where they aren't currently in place. I'll also like to show them the Monthly Summary by Provider so they can see how many transfers they've had for the month, how they compare with other providers, and who is approving the transfers. They might be surprised to see that one of their covering physicians sends a lot of residents to the ED on Friday afternoons or some other trend that the report will show us.

Program Champion: I'd like to include the Monthly Summary by Provider in our quarterly QAA meetings. That way, if we notice a trend, like Jill [Nurse Manager A] mentioned, frequent admissions or ER visits on Fridays or weekends, we could discuss it with the team, which includes Dr. Bishop, our Medical Director. It may make sense to try to schedule a meeting with all of our providers to review our capabilities and our goal of reducing potentially avoiding hospital transfers. If we have Dr. Bishop's support, we'd be more likely to get the providers' attention.

Administrator: I think you're right. Our providers will listen to him.

Facilitator: So, it looks like you want to share the information on the Transfer Risk Report with the Medical Director during his weekly rounds. Also with providers when they visit the units to check on their residents. And, with the consultant pharmacist; how will you engage him regarding the reports?

DON: Each month when the consultant pharmacist comes to the facility, he stops by to leave me his recommendations and discuss anything particularly important. I will print out the report and ask him to take a few minutes to review it with me. Or, it might make more sense, to print the report at the beginning of the day and give to him when he arrives at the facility. That way, he has the information and can use it as he does his medication reviews. Yes, that's what I'll do.

Facilitator: Okay, that sounds good. You also said you plan to use the Monthly Summary by Provider at QAA meetings and with providers as they come to visit their residents. How about the ED Treat and Release Report? If you recall, this report provides information on the reason for transfer, treatments not available at the nursing home, who authorized the transfer, what treatment, tests, and procedures were conducted at the nursing home prior to the transfer, whether the resident was seen in the 24 hours before the transfer, and prior ED and hospital visits in the last month.

Program Champion: I think the ED Treat and Release Report will be very helpful in detecting when discharges are for treatments not available at the nursing home. Now that we have completed our IV training, I would not expect to see residents going out for IV hydration. This will also show us if certain treatments or tests are not getting done before transfer.

DON: Remember when our oxygen supplier had changed and we were not getting our regular deliveries? Every time the nurses went to get oxygen out of the oxygen closet, the tanks were all empty. I think there were about five residents who went to the hospital largely because of this issue before we realized what was going on. Two of them went for shortness of breath, one for bronchitis, one for pneumonia, and one for chest pain. The nurses normally would have put on some oxygen and given them their PRN medications to address their symptoms; but, because there was no oxygen (unless you took it off of somebody else, which they couldn't do), they had to be sent out. It wasn't until several weeks later that we put it together. If I had had this report and could see the reason for transfer was respiratory related and no one had applied oxygen before the transfer, I would have been highly suspicious.

Nurse Manager Unit B: I'll use this on my unit to double check those instances when a resident goes out for dehydration. That's something that we can sometimes prevent, or, for G-tube replacement because someone didn't anchor the tube correctly. Don't get me wrong, I think it's helpful to see these trends over a 3-month period, like we'll be doing at the QAA meeting. But I'd like to be following these incidents more often, at least weekly.

Program Champion: Sometimes seeing information over a longer period will allow us to see trends that wouldn't be obvious on a weekly basis. It's like stepping back and seeing a bigger picture. But I agree it makes sense to follow up on these transfers on a regular basis.

Facilitator: This is a really good discussion of how the various reports can help. Let's circle back to the goals you described at the end of the Self-Assessment session to see where we are. It sounds like you plan to use the ED Treat and Release Report to track residents who are going out for IV treatment. The next item on your list was addressing advance directives on a routine basis. The Transfer Risk Report can help you track which residents have advance directives in place.

Social Worker: Yes, I will use the report to start a review of residents without advance directives in place. Then I'd like to continue reviewing on a routine basis to make sure that each directive is still appropriate. The report will help me prioritize my efforts.

Staff Development Coordinator: I believe that the Monthly Summary of Transfers by Unit or Facility will allow us to monitor the numbers of ED visits, observation stays, and hospitalizations. Of course, I realize that staff training and education is only one potential influence on transfers, but I think the report can help us identify staff education that is needed, especially since the report flags potentially avoidable diagnoses. If we want to monitor over time, we can use the Key Metrics Report.

Facilitator: How can you use the reports to assess your staff education?

Staff Development Coordinator: Nursing leadership has a meeting every week. I report on numbers and topics of recent in-services. I will print out the Transfer Risk Report to track the number of patients with high-risk diagnoses or high-risk change in conditions. If I see an uptick in the number of residents with CHF or diabetes, for example, it may represent an opportunity for education or retraining with nurses or nursing assistants related to care of residents with these conditions. I can use the ED Treat and Release Report in the same way. If I see an increase in the number of transfers due to respiratory, cardiac, or circulatory conditions, there may be a need for nurses to refresh their assessment skills in these areas. The Monthly Summary and Key Metrics reports could be used to monitor any impact on transfers related to recent trainings. We completed our IV training last month so we should not see any transfers related to an IV start. I will review the ED Treat and Release Report for that.

Facilitator: The last goal you mentioned was to improve your root cause investigations of potentially preventable hospitalizations. You collect all the details around an ED visit or hospitalization but don't look deeper to see if there could have been a systems issue involved.

Administrator: We've shared a few examples where we discovered systems issues in our building that affected the safety of our residents. We know this type of in-depth investigation yields results, but sometimes, it just seems like an overwhelming task. To take on this level of investigation on top of everything else going on—the record review, the interviews—we know it's important, but it just doesn't seem possible.

Facilitator: What would make this doable for you?

Administrator: I think if we could prioritize our efforts and focus on the transfers that seem the most "preventable," that might work.

Program Champion: The Monthly Summary displays the number of transfers with at-risk diagnoses and the percentage of each. We could run this by unit and look to see which diagnoses are coming up most often. If we notice that the highest percentage in this category is CHF, we go back to the unit records and review those cases. We could use the Transfer Risk reports for each week of the month to determine which residents were transferred for CHF and then do a thorough investigation on one or two of them.

Facilitator: How does that sound?

Administrator: That might work.

Program Champion: We could do it in preparation for our QAA meeting. We could report on it at the meeting. I'll lead the investigation but will need help from the leadership to conduct the medical record review and interviews with staff and providers.

DON: Thanks. I can help with that.

Administrator: Just let me know what you want me to do.

Program Champion: Good, I think we've made a great deal of progress today. To summarize, the plan is to start using the Transfer Risk Report and ED Treat and Release Report on Unit A to identify transfers related to IV therapy, to make sure that residents' advance directives are up to date, and to highlight residents at highest risk during medical director and provider rounds. We will also use the reports to monitor the effectiveness of staff training and to look for opportunities for education and retraining. Lastly, we will conduct several in-depth investigations of transfers to determine if any system issues were involved. That's a pretty ambitious agenda.

DON: Yes, but you said it yourself, we are a results-oriented team.

Facilitator: In a couple weeks, we'll chat on the phone and you can let me know how it all worked out. Of course, if there are questions before that, you know how to reach me.

Program Champion: We sure do, Tom [Facilitator]. Thanks for all your help.

Scene 2: Change Team Followup Meeting

Setting: It is 2 weeks since the Change Team last met. Reports have been implemented on one unit, Unit A. The team has assembled to discuss how the trial is going.

Program Champion: Thank you all for coming. We're meeting today to hear how the trial of the Preventable Hospital Transfer reports went. Tom [Facilitator] is on the phone.

Facilitator: Hi, everyone. How did it go?

Program Champion: We started using the Transfer Risk Report on Unit A for medical director and provider rounds. Jill, will you give us an update?

Nurse Manager Unit A: Yes, I printed the Transfer Risk Report each week and the ED Treat and Release Report for the month and showed them to Dr. Bishop, our Medical Director. He was very interested in having this level of detail for his residents and for the unit as a whole. He said he now better understands the level of frailty of the residents on our unit. And he said this explains the number of phone calls he gets.

Facilitator: Very interesting.

Nurse Manager Unit A: I knew he'd like having the advance directive information and he sure did. I also had the reports available when Dr. Black, one of our attending physicians, came around and for Jenny, the nurse practitioner. I highlighted their residents on the reports. Dr. Black was particularly interested in the ED Treat and Release Report and the reasons his residents were being transferred and who was authorizing the transfer. I told him about the Monthly Summary of Transfers by Provider and he was very interested in seeing that. Jenny was surprised at the number of hospitalizations and ED visits for her residents. She said that's the first time she had ever seen that level of detail around transfer risk. She would really like to work with me on reviewing orders and putting individualized care plan interventions in place as a sort of early intervention to make sure we're following up on signs of a flare-up of a chronic condition. She agreed to provide an in-service or two to the nurses to help us understand early signs of deteriorating chronic conditions and to work with us to improve our assessment skills. She thinks there's definitely an opportunity to improve our care, especially around care of residents with CHF and diabetes. Sorry, I didn't mean to go on and on and monopolize the meeting. I'm just really excited about the possibilities for improving our skills and care.

Facilitator: That's okay. Glad to hear that it's going well. Anyone else?

Program Champion: We have our QAA meetings quarterly, so we haven't had a meeting since our last discussion. In the meantime, though, I've been reviewing the Monthly Summary and weekly Transfer Risk reports. I've noticed that we have had four transfers since our last Change Team meeting. Discharge diagnoses were dehydration, fall with injury, cellulitis, and angina. Overall, for the entire month, the discharge diagnosis cited most frequently (with the highest percentage) was dehydration. I used the weekly Transfer Risk reports to find the resident with the most recent discharge for dehydration and decided to do a root cause analysis on it. Dehydration was of particular interest because of our recent IV therapy training.

Facilitator: How did the investigation go?

Program Champion: Mary [DON], Betty [Administrator], and I met to discuss how we would proceed. Mary reviewed the medical record, I spoke to the nurse who was on duty when the transfer occurred, and Betty spoke with the primary care provider. We completed our individual tasks over 2days and then met to share our findings.

Facilitator: We don't need to hear all the details of the case, but we are interested in the process and whether you think the On-Time reports can help.

DON: I definitely think the reports can help prioritize our efforts, especially while this is new for us and we're developing and testing our approach. This is definitely a work in progress, but I think there's a huge opportunity here in terms of our ability to continuously monitor the quality of our care. This is exciting. We've had our EMR for several years, but I've never been so impressed with the value of the information until seeing these reports. The information is there. We just need to use it to drive care.

Facilitator: That sounds great. Anyone else want to report on the use of the reports?

DON: The consultant pharmacist was in last week. I printed off the Transfer Risk Report for him. He asked for the monthly version, so I had to explain that it's a weekly report. I let him know that I would start a folder for him and when I print the report for my use weekly, I'll print one for him and leave it in the folder. That way, he'll have the whole month of information when he comes in. I explained that we can work with our EMR vendor to flag hospitalizations related to high-risk medications or polypharmacy. He was very interested in seeing that.

Staff Development Coordinator: I printed the Transfer Risk Report and brought it to the nursing leadership meeting to review the high-risk diagnoses and high-risk change in conditions and to brainstorm with the team on topics for upcoming in-services. Jill [Nurse Manager A] mentioned her discussion with Jenny, the nurse practitioner, and we decided to try to coordinate something with her. I was thinking that maybe we could get Dr. Bishop to provide an in-service to the nurses on either CHF or pneumonia and that Jenny could provide some instruction and hands-on practice regarding conducting respiratory assessment. That would be a great refresher for the nurses.

DON: What a good idea.

Facilitator: You have all done a great job. Have you thought about expanding the rollout of On-Time?

Nurse Manager Unit A: I'd like to continue using the Transfer Risk Report and ED Treat and Release Report on medical director and provider rounds.

Nurse Manager Unit B: I'd like to get started using those reports as well. Any reason I couldn't get started next week?

Program Champion: That sounds reasonable. If everyone agrees, I think we'd like to continue using the reports with the consultant pharmacist, to inform our training efforts, and for QAA in order to better develop our root cause analysis approach.

Change Team: Yes, that's right. We agree.

Facilitator: I'll be eager to hear how it goes. You should be proud of the work that you have done thus far. Well done.